Revision: HCFA-AT-91-4(BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Kentucky

Citation		
42 CFR 447.51 through 447.58	4.18 (a)	Recipient Cost Sharing and Similar Charges Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
1916(a) and (b) of the Act	(b)	Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19

[ ] Age 20

[ ] Age 21

X Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

- Recipients between the ages of 18 and 21 who are in state custody and are in foster care or residential treatment are exempted from copayments.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

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Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women. women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[X] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[ ] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-AT-84-2 (BERC)
01-84

State/Territory: Kentucky

Citation	4.23	Use of Contracts
42 CFR 434.4 48 FR 54013		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.
		/__/ Not applicable. The State has no such contracts.
42 CFR Part 438		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):
		___ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
		___ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
		___ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
		__X_ Not applicable.

New: HCFA-PM-99-3
JUNE 1999

State: Kentucky

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Kentucky

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act		(1) Section 1902(p) of the Act by excluding from participation—
		(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808		(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
		(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
		(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610		(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438,610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991
State: Kentucky

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.212 & [ ] 1902(e)(2) of the Act, P.L. 99-272 (section 9517), P.L 101-508 (section 4732)

3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

X The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility. The minimum enrollment period is _ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than Medically Needy (continued)

1932(a)(4) of the Act

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

___Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

___ No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

_X__ The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

Citation	Condition or Requirement

1932 (a)(1)(A)

A. Section 1932 (a)(1)(A) of the Social Security Act.

The State of Kentucky enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (i.e. managed care organization (MCOs) and primary care case managers (PCCMs) in the absence of section 1115 or section 1915 (b) waiver authority. This authority is granted under section 1932 (a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may not be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), or to mandate the enrollment of Medicaid beneficiaries who are Medicaid eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet eligible certain categories of "special needs" beneficiaries (see D.2.i.-vii.)

B. General Description of the Program and Public Process.

1932 (a)(1)(B)(i)
1932 (a)(1)(B)(ii)
42 CFR 438.50 (b)(1)

1. Describe the contracting entities by indicating if they are an MCO or PCCM.

The State enrolls Medicaid beneficiaries into PCCMs.

42 CFR 438.50 (b)(2)
42 CFR 438.50 (b)(3)

2. Discuss the payment method to be utilized (i.e. fee for service, capitation, case management fee, bonus/incentive and/or supplemental payments).

The PCCM receives a monthly case management fee of $4.00 per member per month. Services are paid on a fee-for-service basis.

42 CFR 438.50 (b)(4)

3. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.

The PCCM program, Kentucky Patient Access and Care System (KenPAC) was initially implemented by the state as a 1915 (b) waiver in 1985. By the time that the state implemented the program under 1932 authority, it was a mature PCCM model that required only minimal changes to be compliant with the requirements of the Balanced Budget Act.

The State began planning in 2000 to enroll the SSI population into KenPAC. Meetings were held with various advocacy groups and community agency representatives. Relationships were formed to assist the State in its

Citation	Condition or Requirement
	outreach and education efforts. Additionally, forums were held across the State to allow for questions from recipients, advocacy groups, and other community agencies. Notifications were sent to recipients in January 2001 and a Help Desk was established within the agency. Enrollment was phased in over several months. Ongoing participation is assured through regular meetings of the Physician Technical Advisory Committee. A toll-free telephone line is available for public and recipient questions and complaints.
1932 (a)(1)(A)	4. Affirm if the state plan program will implement mandatory enrollment into managed care on a statewide basis. If not, identify the county/areas where mandatory enrollment will be implemented. The state plan program will be implemented in all areas of the state where the state does not operate a managed care program under an 1115 waiver. Counties without an adequate number of PCCMs will be excluded.
	C. State Assurances and Compliance with the Statute and Regulations. The state assures all the applicable requirements that include but are not limited to the following statute and regulations are met:
1932 (a)(1)(A)(i)(I) 1903 (m) 42 CFR 438.50 (c)(1)	1. Section 1903 (m) of the Act, for MCOs and MCO contracts.
1932 (a)(1)(A)(i)(I) 1905 (t) 42 CFR 438.50 (c)(2) 1902 (a)(23)(A)	2. Section 1905 (t) of the Act for PCCMs and PCCM contracts.
1932 (a)(1)(A) 42 CFR 438.50 (c)(3)	3. Section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.
1932 (a)(1)(A) 42 CFR 431.51	4. 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905 (a)(4)(C).
1932 (a)(1)(A) 42 CFR 438 42 CFR 438.50 (c)(4) 1903 (m)	5. 42 CFR 438 for MCOs and PCCMs.

Citation	Condition or Requirement
1932 (a)(1)(A) 42 CFR 438.6 (c) 42 CFR 438.50 (c)(6)	6. 42 CFR 438.6 (c) for payments under any risk contracts.
1932 (a)(1)(A) 42 CFR 447.362 42 CFR 438.50 (c)(6)	7. 42 CFR 447.362 for payments under any non-risk contracts.
45 CFR 74.40	8. 45 CFR 74.40 for procurement of contracts.
	D. Eligible groups.
1932 (a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. Enrollment in KenPAC is limited to AFDC related recipients, Family Related Medicaid recipients, Poverty Related Women and Children, Kentucky Children's Health Insurance Program (KCHIP), SSI recipients age nineteen or above, SSI Related Medicaid recipients and State Supplementation recipients.
	2. Mandatory exempt groups. The following populations are exempt from enrollment in KenPAC: Individuals who meet the eligibility requirements for receipt of both Medicaid and Medicare (dual eligibles); American Indians who are registered members of a Federally recognized tribe; Children under 19 years of age who are eligible for SSI under Title XVI, described in section 1902(e)(3) of Title XIX of the Social Security Act, receiving foster care or adoption assistance under part E of Title IV, receiving foster care or otherwise in an out-of-home placement, in the custody of the Department of Juvenile Justice and placed outside of the home, or receiving services through a family-centered, community based coordinated care system receiving grant funds under 42 USC 501(a)(1)(D). Use a check mark to indicate if the state will enroll any of the mandatory exempt groups on a voluntary basis.
1932 (a)(2)(B) 42 CFR 438 (d)(1)	i. Recipients who are also eligible for Medicare ___The State will allow these individuals to voluntarily enroll in the managed care program.
1932 (a)(2)(C) 42 CFR 438 (d)(2)	ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health